SERVICE PLAN

To be developed within 30 days of admission by the manager, or designee, in collaboration with the Delegating Nurse/Case Manager (DN/CM). To be reviewed, & updated if needed, at least every 6 months, or sooner if there are significant changes to a resident's condition or preferences.

Resident:			DOB:	Service Plan Date:		
Code Status:			Admission Date:			
on the Resident Assessment		on the Resident Assessment Tool). In the re	the resident's medical/mental health diagnoses that are currently being treated (based Tool). In the remaining columns document the services & care needs related to each outions, monitoring, or lab tests related to high-risk medications.			
Risk Factors/ Precautions:						
				Services To Be	e Provided	
Medical/Mental Health Diagnosis	9	Services To Be Provided & How They Will Be F	Provided	When & How Often (If "other" specify.)	By Whom	
				☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other		
				☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other		
				☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other		
				☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other		

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Resident: D		Service Plan Date:	Date:		
MEDICAL/MENTAL HEALTH NEEDS (Continued)					
Medical/Mental		Services To Be Provided			
Health Diagnosis	Services To Be Provided & How They Will Be Provided	When & How Often	By Whom		
		☐ Hourly☐ Daily☐ Weekly☐ Monthly☐ Other☐			
		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other			
		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other			
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		☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other			
		☐ Hourly☐ Daily☐ Weekly☐ Monthly☐ Other			

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PERSONAL CARE NEEDS *If the resident is Independent & requires no services related to the activity, check "I" & skip to the next activity.		DOB: Service Plan Date: Degree of Help Needed I = Independent* S = With Supervision, Set-up, or Cuing & Coaching TC = Total Care			
the degree of help needed.)	(Based on the Resident Asses	ssment Tool & nursing assessment.)	When & How Often	By Whom	
Eating	Indicate any dietary needs, such as monitoring	g, diet orders, supplements, restrictions, food	☐ Hourly	-	
□I □S □A □TC	preferences, eating patterns, etc.		□ Daily □ Weekly □ Monthly □ Other		
Medication Administration □ I □ S □ A □ TC			☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other		
Continence			☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly		
Mobility (Includes bed mobility, using			☐ Other ☐ Hourly ☐ Daily		
stairs, & transfers to bed, chair, or toilet)			☐ Weekly ☐ Monthly ☐ Other		
Bathing			☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other		

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Resident:		DOB:	Se	rvice Plan Date:		
If the resident is Independent 8 check "I" & skip to the next activ	& requires no services related to the activity,	Degree of Help Needed I = Independent S = With Supervision, Set-up, or Cuing & Coaching TC = Total Care				
(Check one box to indicate		d & How They Will Be Provided		Services To Be	Be Provided	
the degree of help needed.)	(Based on the Resident Asse	essment Tool & nursing assessment.	: <i>)</i> v	When & How Often	By Whom	
Oral Care				Hourly □ Daily		
□I □S □A □TC				Weekly □ Monthly Other		
Grooming				Hourly □ Daily		
3				Weekly □ Monthly		
□I □S □A □TC				Other		
Dressing				Hourly □ Daily		
				Weekly □ Monthly		
DI DS DA DTC				Other		
			·			
BEHAVIORAL/COGNITI	VE NEEDS	How Often The Issue Occurs				
DEIIATIONAL, COOMITI						
If an issue never occurs, check		N = Never	R = Regular C = Continuous			
If an issue never occurs, check	"N" & skip to the next item.	N = Never	C = Continuous	Services To Be	e Provided	
	"N" & skip to the next item. Services To Be Prov	N = Never* O = Occasional	C = Continuous	Services To Be		
If an issue never occurs, check (Check a box to indicate ho	"N" & skip to the next item. Services To Be Prov (Based on the Resident A	N = Never O = Occasional vided & How They Will Be Provided	C = Continuous Inent.)	When & How Often Hourly	e Provided By Whom	
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Resident:		DOB: Service Plan Date:			
BEHAVIORAL/COGNITIVE NEE	DS (Continued)	How Often The Issue Occurs			
If an issue never occurs, check "N" & skip	to the next item.	N = Never	R = Regular		
	Condens To Do Donaldad	O = Occasional	C = Continuous Services To Be Provided		
(Check a box to indicate how often the issue occurs.)	Services To Be Provided & How They Will Be Provided (Based on the Resident Assessment Tool & nursing assessment.)			By Whom	
Disturbed Sleep Pattern □ N □ O □ R □ C	(basea on the Resident Asses.	sment roof & narsing assessment.)	When & How Often ☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other	by Wilom	
Ineffective Communication (Cannot express needs, ideas, or wishes) □ N □ O □ R □ C			☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other		
Resists Care or Assistance			☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other		
Impaired Judgment (Makes decisions harmful to self or others) □ N □ O □ R □ C			☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other		
Wanders or Elopement Risk □ N □ O □ R □ C			☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other		
Agitation (Easily upset or unsettled) □ N □ O □ R □ C			☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other		
Disruptive Behaviors (Yells, demands attention, takes others possessions, or inappropriate behaviors) □ N □ O □ R □ C			☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other		
Combative/Aggressive Behaviors (Throws objects, strikes out, or otherwise harms others)			☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Other		
Hallucinations or Delusions □ N □ O □ R □ C			☐ Hourly ☐ Daily☐ Weekly ☐ Monthly☐ Other		

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Resident:		DOB	::	Service Plan Date:		
OTHER		Details				
Resident's background						
Resident's likes 8	& dislikes					
Resident's spiritu	ual needs					
Resident's currer	nt daily routine					
Resident's participation in programs outside the facility						
Resident's finances		☐ Family, resident, or resident's representative manages all financial matters independently ☐ Resident manages financial matters with supervision ☐ Assisted living program manages finances				
Transportation		☐ Travels independently, all modes of transp☐ Needs some assistance/escort☐ Complete assistance/needs specialized veh				
Signature of Person Completing the		Service Plan:			Date Completed:	
Signature of Delegating Nurse/Case		Manager (DN/CM):			Date Reviewed:	
		Service Pla (Every 6 months, or more frequently in		v cignificant changes \		
Date	Reviewed By M	Anager/designee (signature)	Date		ed By DN/CM (signature)	
	-	•				